Correspondence

Letters should not exceed 400 words and should be typed double spaced (including the references) and be signed by all authors.

TO THE EDITOR *Genitourinary Medicine*

Chlamydial infections of the urethra in women

Sir,

While agreeing with Bradley *et al* *Genitourin Med* 1985;**61**:371-5) in almost all respects, we disagree with their conclusion that "there seems to be no indication for taking routine urethral swabs to aid in the diagnosis of chlamydial infection in women" and present a simple inexpensive alternative protocol.

The mechanics of sexual activity mean that the infected urethra is always a potential reservoir for infection of the cervix. Our experience is based on two studies. In the first, specimens for culture for chalmydiae were collected from the urethra and cervix of 176 pregnant women at the time of their first antenatal visit. Twelve cultures were positive for *Chlamydia trachomatis* and 2/12 (17%) were positive only in the urethral specimen.[1] In the second study specimens were similarly collected from 180 women attending a sexually transmitted diseases (STD) clinic. Eighteen cultures were positive for *C trachomatis* and 4/18 (22%) were positive in the urethral specimen alone.[2] Though the percentage of patients yielding positive specimens from the urethra alone was high, the absolute number was small. It is therefore uneconomical to collect routinely separate cervical and urethral specimens for chlamydial culture.

The following protocol was devised in an attempt to contain costs while not missing patients who were harbouring chlamydiae in the urethra but not in the cervix. Using a cotton wool wire shafted swab, a specimen is first collected from the cleansed urethra and placed into a bottle of chlamydia transport medium (CTM). The cervix is then visualised and cleansed, and a further swab from the endocervix is placed in the same bottle of CTM. The eluate from these two swabs is then cultured on cycloheximide treated McCoy cells in the usual way, the result reported, and treatment instituted if necessary, irrespective of the specific site infected being known.

In this way, at the cost of an additional swab infections of both the urethra and cervix are detected and treated, which results in a corresponding increase in detection rates from female genital tracts and avoids possible sequelae.

Yours faithfully,
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References

1. Bucens MR, Roberman BD, Ott AK, Gollow MM. Chlamydial infections in pregnancy. *Med J Aust* 1984;**141**:134-5.
2. Gollow MM. *Chlamydia trachomatis* in the female genital tract. Proceedings of chlamydia conference, Menzies School of Health, Darwin, Northern Territory, Australia (in press).

TO THE EDITOR *Genitourinary Medicine*

Detecting chlamydiae in diagnosing and managing women with abdominal pain

Sir,

Munday *et al (Genitourin Med* 1986;**62**:15-6) detected cervical chlamydial infection in 42 of 232 (18%) women attending the Praed Street Clinic with abdominal pain not diagnosed as having pelvic inflammatory disease. Regrettably they did not include a matched control group of clinic patients who did not have abdominal pain to assess the prevalence of chlamydiae in them.

In Newcastle we are fortunate in being able to screen routinely all our female patients for chlamydial infection by cell culture. The table shows our results since 1983.

TABLE *Result of routinely screening female patients for chlamydia*

Year	*No tested*	*No (%) positive*
1983	2364	452 (19·1)
1984	2609	402 (15·4)
1985	3063	534 (17·4)

Thus in the past three years we have screened 8036 women and detected chlamydiae in 1388 (17·3%). Though high risk groups (such as contacts of patients with non-gonococcal urethritis or gonorrhoea) were tested, a notable proportion (37%) of positive patients were from low risk groups (such as those attending with an episode of candidiasis or with warts).

Before advising that those with abdominal pain should preferentially be selected for a chlamydial diagnostic service, comparative data should be presented on clinic attenders without abdominal pain.

Yours faithfully,
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TO THE EDITOR *Genitourinary Medicine*

Minocycline in the treatment of genital chlamydial infection in women

Sir,

Tetracyclines or erythromycin are the recommended antimicrobials for the treatment of genital infection with *Chlamydia trachomatis*.[1] The optimum therapeutic regimens of these agents still require investigation, as shown by two recent contributions on erythromycin to *Genitourinary Medicine*.[2,3]

Minocycline 50 mg twice daily for seven days has been shown to be as effective as longer regimens and higher doses of this tetracycline for treating urethral infection with *C trachomatis* in men.[4,5] No similar study of the use of minocycline for treating genital chlamydial infection in women has been reported, and this antimicrobial is not listed in a recent summary of treatment regimens in women.[6] We have recently evaluated minocycline 50 mg twice daily for seven days in the treatment of genital infection by *C trachomatis* in women.

From February to October 1983 we performed cervical culture for *C trachomatis*, using cycloheximide treated McCoy cells, on 603 patients; those who had taken antimicrobials during the preceding four weeks were excluded, but patients were otherwise unselected. *C trachomatis* was isolated from 222 women. Of these, 79 were contacs of men with non-gonococcal urethritis and the remainder had yielded *C trachomatis* after